

INTER-OFFICE CORRESPONDENCE

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Med. case

JUN 11 1943

FROM: RBF

DATE: June 11, 1943

TO:

JD		22
15	JUN 14 '43	14

COMMENTS:

An excellent analysis. The analogy of the public school system is very apt. Statistics of general disease on a national scale would play a big part in abolishing racial segregations. 22.

SUBJECT:

At the meeting of the Trustees last December, there was some discussion of the general question of what has come to be called "social medicine," and President Dodds asked Dr. Gregg whether he would be willing to prepare a descriptive statement of what is meant by this phrase.

Dr. Gregg has complied with this request and I am sending herewith a copy of his statement. - filed

RBF

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copy sent to all officers and Trustees

one copy to be kept for January 1945  
for medical library

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## SOCIAL MEDICINE.

### Scope of Social Medi- cine.

Social Medicine is concerned with the study of man as a total individual in all aspects of the complex elements that make up the living man. Social Medicine is the latest comer in the field of medicine and is only now in process of development as a science. The maintenance of health, prevention of illness and cure of disease will not become fully attainable until social medicine has also been fully developed as a science. Text books ordinarily imply description of accepted techniques and methods of practice. The science of social medicine is, however, only in its initial stage at present. Its practice is still largely empirical and chiefly through the humanitarian political provision of the various social assurances including housing, children's allowances, health insurance, old-age pension, etc. However, inclusion of reference to Social Medicine is considered necessary in the present edition of "Hygiene and Public Health" because of its increasing significance.

Ryle points out that social medicine is the beginning of the third epoch of preventive medicine. The first was concerned with environmental conditions and prevention of epidemics. The second epoch of Virchow and Pasteur associated with the fundamental advances in chemistry and physics resulted in the development of medical techniques, the preventive aspects of which were applied to what now are termed the personal health services and the control of communicable diseases. With the introduction of home visiting through the development of public health nursing and hospital social service in connection with the personal health services, gradually consciousness grew up that many of the non-infective diseases are preventable, particularly those associated with faulty habits of life or conditions of living. This extension of epidemiological knowledge relating to health and illness and based on the cornerstone of increased use of biostatistics has led to the extension of specific preventive measures and the consequent development of social medicine to include all factors necessary for positive health. The following description is necessarily limited to indicating the preliminary steps required for its development, particularly in India where hitherto even its empirical practice has been absent. Methods and techniques of application remain to be worked out chiefly through medical colleges.

To maintain the human body in health it is necessary to have a knowledge of the entire human system and the mechanism underlying it. In other words, man as a unit of society must be studied extensively and intensively both as a living mechanism and as the essential element of human society. An understanding of the way in which problems involving the patient as a person bear on a given illness is as essential for sound diagnosis and effective treatment as the medical history, physical diagnosis and all the technical procedures now available to the physician. It often happens that the personality of a patient tends to be lost in the highly specialised and complicated organisation of medical service as it exists today. The sick man comes to the doctor with family ties and other human interests and responsibilities. The patient may not suspect and the doctor may not realise how the pattern of his life affects his illness, but a complete review of his life may sometimes let in a flood of light on problems of diagnosis and treatment.

Canby Robinson, a pioneer in the field of social medicine, discusses illness as contrasted with disease and reviews some of the present attitudes regarding the study and teaching of medicine. He defines "illness" as a state in which certain natural functions are so disturbed that the patient cannot meet the usual requirements of life, as distinct from "disease" which is an abnormal state of the body resulting from harmful effects of processes, injurious substances or medicaments. As such, disease is only one element of illness and is not the only cause of disturbances of the activities and functions of the body. Disease does not necessarily cause illness and illness may exist without disease. Physiology, Chemistry and Biology do not explain all the intricacies of illness. This has been borne out by the following observation from a study of unselected patients admitted to the Johns Hopkins Hospital:-

Adverse ...

Adverse social conditions had a definite relation to the illness of 66 per cent. These conditions caused harmful emotional effects in 58 per cent of the patients, and in 20 percent produced emotional reactions that were considered to be the chief cause of illness. In 15.5 per cent of the cases a study of the state of their social situation furnished significant and essential information for the complete diagnosis of their illness, while in treatment it was found that adverse social conditions were a significant factor in 71 per cent of the cases.

In brief, the present highly specialised services of medicine may study the disease with great care, but neglect the illness. Social medicine is concerned with understanding and assisting man in all main and contributory factors inimical to positive health, and with the lowering of the incidence of all preventable illnesses and raising the general level of human fitness physical as well as mental and spiritual. As such, social medicine becomes a branch of social sciences and a field of social service applying practically every basic science directed towards a comprehensive programme of community medical protection for the purposes of maintaining health, preventing illness and curing disease.

It is only recently being acknowledged that not only illnesses but many organic diseases have their origin in social, domestic or industrial mal-adjustment, economic insecurity or dietary insufficiency. The science of man implies the interdependence of clinical, social and environmental studies to understand completely the knowledge and its application required for the maintenance of health, prevention of illness and the cure of disease. This extension of objective is characterised by Canby Robinson as following the patient into life, instead of to the autopsy table. This extension not only envisages a re-orientation of existing preventive medicine and public health, but requires through the right type of health education, as an essential part of a broader general education, the creation of a public able to participate in the fullest human wellbeing. The foregoing implies that the task of social medicine is, on the one hand, to develop medicine in relation to social life and, on the other, to influence social activities in the interests of human well-being. The universal development of social security through some form of social assurance, as well as of universal education is a humanitarian evolution towards recognition of man's place in society. It thus becomes the responsibility of medicine to develop specific knowledge in relation to social life. Professor Ryle has emphasised the socio-medical problem involved as illustrated by findings already available concerning influence of class, occupation and geography on health and as observed in such specified problems as neonatal mortality, rheumatic fever, gastric ulcer and the increasing group of psycho-neurosis, etc. In brief, the differentiation of social medicine marks the beginning of a new and widened epoch in the evolution of medicine and which produces the re-oriented practitioner of medicine helped by a social worker to assist him in diagnosing and treating the socio-economic factors of illness analogous to the assistance rendered hitherto in the diagnosis and cure of disease by the nurse. Similarly, the public health administrator as well as the general practitioner, must be reoriented in his education to the essential significance in health of the education of the public for healthful living and which requires a hygienic socio-economic environment. Training must include sociology and economics, a much greater emphasis on physical and social anthropology and biology as well as social medicine itself if the product of training is to discharge his responsibility in the development and place of social medicine in the evolution of the "good life".

Scope, functions and training of social workers. It has been stated that the development of medicine in relation to its proper place in social life implies a reoriented medical profession utilising social workers. The training of social workers in India is envisaged in the recommendations of the Bhore Health Survey and Development Committee (1944). In view of the absence hitherto in India of such service it becomes essential to describe the scope, functions and training of social workers in order to indicate the steps which will have to be undertaken. The necessity for utilising social workers arises out of the recognition of the futility of treating a patient for pathological conditions produced or aggravated by unhygienic living and then exposing him again to the same conditions. The important thing

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in diagnosis is a review of the entire life of the individual from birth to death, with special reference to the causes contributing to the present illness to discover and make available to the physician any factors in the patient's environment that may have a bearing on his physical condition, thus supplementing medical history by social history. This would include any facts of heredity, personality, manner of life, home environment, financial worries, dependents, character of employment and strains and hazards incidental thereto, recreations and standard of living generally. It is in this direction that the services of a medical social worker are invaluable to the physician. The medical social worker is now recognised as an essential professional colleague of the doctor in the analysis and treatment of the social and emotional disturbances of patients and is increasingly becoming relied upon for supplying information that is of fundamental significance in formulating the complete diagnosis and in directing the treatment of many patients. As such, the medical social worker forms the link between the hospital and the community from which the patient comes and to which he returns. It is her duty to investigate the social status of the patient and to evaluate the significance of adverse social conditions in relation to the particular type of illness. The social worker is called upon to use her professional skill and knowledge to effect desirable changes in the relationship of the patient and his human and physical environment. When the physician discovers or suspects social problems it should be his duty to refer the patient to the social worker, defining for her the specific social and emotional disturbance of the patient and his special needs. Thereupon it is the duty of the social worker to go thoroughly into the patient's life and make available such information as will enable the physician to comprehend and treat the patient's illness effectively, hasten and safeguard his recovery and help prevent any recurrence. Today the functions of a hospital social service have been defined in England as follows:

1. Service to the patients as a part of hospital therapy.
2. Service as a connecting link between the hospital and the public in the treatment of the individual patient and the general health programme of the area covered.
3. It serves to create better understanding through interpretation of the hospital to the public, and the public to the hospital, strengthening the work of both by bringing about better results.
4. It serves to assist in research by studying groups of cases and helping to remove causes of disease, and increasing facilities for complete treatment and when the need is indicated by such study.
5. It makes a definite contribution to the education of medical students, nursing pupils, and general social workers.

Training of social service workers is now provided in England by 18 social science departments of Universities. Students take certificates or diplomas, but not degrees as in the United States, although these are now under consideration. The diploma courses usually last two years. The syllabus includes university standard courses on some or all of the following: Economics, sociology, psychology, industrial law, industrial history and organisation, public administration, criminology, psychopathology, machinery of government, social statistics, social insurance. Equally important is the student's eleven months' field work under supervision. The student works as the junior member of a medical social service and is taught by a senior member who discusses the details of her work fully and frequently. The supervisor is a counsellor as well as an instructor; she is concerned with the wide implications of the student's work and with the student's personal adjustment in a period of rapid, and perhaps difficult, development. Meanwhile the student gains both in experience and in self-reliance, learning a great deal about the way that people feel and live and work, about the social service structure, and how to mobilise the various resources. Supervisors supply the Universities with full reports on their students, none of whom can qualify without satisfactory reports on field-work.

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The complementary nature of psychiatry and social medicine has been emphasised by interim reports on these two subjects of the Royal College of Physicians (1943). Many mental disorders are becoming increasingly recognised as the result of social and environmental mal-adaptation, particularly the neuroses. The hospital social worker is especially responsible for this group of diseases since much of both diagnosis and treatment depends on her. Consequently specially trained psychiatric social workers constitute an important branch of hospital social service. The psychiatric case worker has the task either through direct interviews or with relatives and friends of evaluating the home situation required in formulating any plan for readjustment. It is also the task of the case worker in the period preceding the patient's examination by the psychiatrist and psychologist to prepare a report on the patient's home situation. In the case of neuroses it is the aim of hospital treatment to readjust the patient to meet effectively his social and environmental situations. The chief instrument to effect this is the psychiatric social worker.

Integration of Social Medicine in Medical Education. The trend of medical education in producing a re-oriented general practitioner is indicated in the Interim Report, 1943, Social and Preventive Medicine Committee, Royal College of Physicians of London. The Report envisages the establishment in University Medical Colleges of Departments of Preventive and Social Medicine. The essential features of the curriculum are indicated under three heads, i.e. theoretical, practical and social aspects with the end that the aim of instruction should be (a) to indicate to the student some of the personal, industrial and social factors which contribute to the causation of human disease, (b) to demonstrate the structure and working of the preventive and remedial organisations provided by public and voluntary agencies with the object of modifying or counteracting the effect of these casual factors, and (c) to train him in the practice of social investigation so that he may be able in the practice of his profession to use the appropriate social technique to reinforce his therapy.

The foregoing implies that adequate instruction in social and preventive medicine requires the availability of two facilities not yet developed in India: (1) hospital social service, and (2) provision to the department of Preventive and Social Medicine of community facilities in public health subjects corresponding in control and in standards to those of teaching hospitals in the clinical subjects.

The necessity of the Department of Preventive and Social Medicine controlling urban and rural community fields for investigation and teaching is analogous to the provision to preclinical sections of their own laboratories and to clinical sections of their own teaching hospitals. Such community fields are used for the teaching of both preventive and social medicine. Preventive medicine should be an integral part of clinical clerkships. The teaching of preventive medicine is designed to inculcate viewpoints and habits in the medical students so that as a general practitioner he will undertake responsibilities for early diagnosis and preventive treatment of illness through the experience and habits obtained from his field work in the personal, industrial and social factors contributing to the cause of the illness. The second teaching purpose of the community fields is to provide the student, by actual participation, with practical experience of community organisation (public health) for prevention and remedy of causative factors of disease. The teaching utilisation for these two purposes of such community fields are in general as follows:

Preventive routines in the hospital and outdoor are under a special officer from the Department of Preventive and Social Medicine of the College, detailed specifically to the hospital to supervise the cases and the students' routines. Briefly the latter are as follows: All patients coming to the hospital from the controlled urban area are designated by record forms of a special colour in order that students and hospital staff are aware of the patients' residence. The Registrar notifies the names of all such cases immediately to the Department's health officer at the area Health Station. The reports of the results of any preventive measures undertaken are sent from the Health Station for inclusion in the patient's hospital record. In the meantime, if the patient is a hospitalized case, the medical clerk after completing his clinical diagnostic routines, and if the case comes under one of previously defined diseases, goes to the patient's home to determine the social-environmental or specific micro-biological

microbiological factors causing the disease and to prescribe the preventive measures that may be indicated in each instance. This the student adds to his record of the case. Then, on ward rounds, the student presents two aspects of diagnosis; first, as to the clinical condition; and second, as to the social aetiological factors together with, in each instance, the indicated therapeutic or preventive recommendations. Diagnosis and therapy are then commented upon consecutively by the clinician and the health officer. In case of death and autopsy, the case is presented at the routine clinical-pathological-conference where diagnosis, aetiology and prevention are discussed jointly by the pathologist, clinician and the health officer.

Social medicine is so intimately integrated with organised community effort for maintaining health, preventing illness and curing disease, through public health organisation and administration, that the syllabus producing the reoriented general practitioner requires that the student should receive instruction in the collectively organised community aspects of public health through instruction designed to provide the general practitioner with an intelligent background as to the scope of public health administration. This instruction must afford opportunity for the student to learn through participative experience under supervision. Instruction should be in the last two clinical years. The introduction consists of lectures on the historical development and principles of public health, and a demonstration-survey of disease producing conditions and of public health work as practised to control them. A clerkship in the final year provides field work with conferences in public health. Finally the training of the basic doctor provides a compulsory one-year internship including a period in public health.

The size of population of the community field is based upon the same principle as for laboratory space or hospital beds, namely to provide sufficient opportunity for participative work on the part of the student on the one hand, and on the other, to provide an overall picture of a self-contained unit of administration inasmuch as an important function of public health is "administration". Also the community unit in question should conform to demarcated political administrative areas. Generally speaking an urban area should not be less than 200,000 population and a rural not less than 400,000 to 500,000 population. With regard to personnel and cost, the principle of administration and finance is that the College in question nominates a member of its teaching staff to the local public health authority, who is appointed as medical officer of health and whose salary is a charge on the College. The local authority contributes financially towards administration to the extent of the cost of similar areas which it administers elsewhere. Additional expenses over and above this which may be required to provide a standard suitable for teaching or investigation is a natural responsibility of the teaching institution.

The foregoing envisages a medical college as an organic whole entirely under the university with full time teachers and consisting of the three groups of differentiated fields in preclinical, clinical and public health. The minimum public health differentiated fields would be public health administration and social medicine; epidemiology; impersonal health services; and, personal health services. The section of public health administration and social medicine will not only have the responsibility of administering the community fields, but it would also be responsible for the routines of preventive medicine in the hospital.

The introduction of social medicine into India implies, in the first instance, its demonstration in reorganised medical colleges on the lines indicated above.

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## NATION BUILDING RECONSTRUCTION

The question is raised of the extent to which it will be possible to carry out a simultaneous attack on all fronts of nation building activities. There is already in existence some kind of activity in each nation building department. The organisation in medical and public health is so incomplete and ineffective that while it can be improved to effect its limited objective more effectively, it cannot constitute the starting point for post-war policy and programme, which will have to be entirely on a different level in order to serve as the foundation for the eventual long term programme. The necessity for such complete reorientation in post-war planning of medical and public health may well exist in other nation building activities. The extent that a simultaneous attack on all fronts of nation building activities may be carried out might well be decided after certain preliminary steps have been initiated in line with the following considerations:

1. Each nation building activity must necessarily have a short term (say of 5 - 10 years) and a long term programme for the post-war period. The short term programme must also outline the organisation, methods and techniques required to work it, to be demonstrated in a limited area, and where personnel could be trained.

2. Even were funds available it will require years to produce the technical personnel necessary to implement the long term programme because of the absence of such personnel at present.

3. It is probably economically impracticable to extend any short term programme, which constitutes a point of departure for the long term programme, on a province-wide scale in the first 5 to 10 years.

4. The foregoing is exemplified in the thinkings of the Bhore Committee. Bengal may be taken as an example to illustrate the above.

(a) The long term programme for medical and public health services costing Rs. 30 per capita per annum would involve an expenditure of Rs. 180 crores for the whole province. It is anticipated that to implement any minimum portion of the long term programme to be productive of significant results would cost Rs. 3 per capita per annum. Apart from lack of personnel, an expenditure of Rs. 18 crores is beyond the immediate capacity of the province. It is, however, thought that the province should be in a position at least to spend Rs. 3 crores or 8 annas per capita per annum for the first short term programme on medical relief and public health.

(b) The existing organisation in Bengal for medical protection is limited in design as compared with the objectives of the long term programme. Even this limited organisation is inefficient because of the following 4 reasons:

- i) personnel are inadequate in number,
- ii) even existing personnel are not trained in the most effective techniques,
- iii) inadequate technical supervision of peripheral personnel,
- iv) decentralisation of health services before experienced traditions and public opinion have had time to develop.

(c) Bearing in mind the personnel and economic limitations as well as the foregoing considerations, the Bhore Committee's short term recommendations envisage two lines of activity; first, to improve the existing organisation through removing the above causes of inefficiency and thereby to achieve its limited objective more effectively on a province-wide scale, and second, to demonstrate the initial stages of the objectives of the long term programme in a limited area. The per capita cost of improving existing health and medical organisation in a demonstration-training sub-division is annas -/11/- and the per capita cost of demonstrating the initial stages of the long-term programme is Rs. 3/-." In the first instance it will be necessary to establish a Subdivision as the field area for demonstrating both short-term programmes, if for no other reason than to provide facilities for training personnel in the techniques and methods required for extension



on a province-wide scale.

5. The foregoing line of reasoning of the Bhoré Committee in regard to medical relief and public health might well apply to the other nation building activities. Each province should be able to afford immediately the cost of a demonstration to effect improvement in the existing organisation to achieve laid down objectives, as well as a demonstration of the initial phases of the long term programme. It cannot, however, be over-emphasised that such demonstrations will not succeed unless the best available personnel are posted, in the first instance, for this undertaking. Each demonstration would require at least two years to work out. In each of the fields of the short term programme there should be provision for a joint simultaneous demonstration of all nation building activities in a concentrated area. The guiding principle here is that the eventual level reached by reconstruction plans in any individual nation building sphere is determined by the extent of coordination obtained from the simultaneous inauguration of reconstruction programmes in other nation building services. Existence of actual demonstrations of reconstruction programmes would then permit decision as to priorities and to what extent economic practicability would permit a province-wide extension of each nation building activity. In addition, each field of nation building activity should in any case have its own demonstration-cum-training field for the same purpose as indicated with reference to public health, i.e. demonstration of techniques and methods and the provision of facilities to train personnel in successful methods.